

ANNUAL UTILIZATION REPORT OF SPECIALTY CARE CLINICS - 1999

Surgical, Chronic Dialysis, Rehabilitation, Psychology, ABC Clinics

STATE USE ONLY
Page 0, Line 1

Col. 3
STATUS _____

Return **BY FEBRUARY 15, 2000** to:
Office of Statewide Health Planning
and Development
Accounting and Reporting Systems Section
Licensed Services Data and Compliance Unit
818 K Street, Rm. 400
Sacramento, CA 95814

Completion of this "Annual Utilization Report of Clinics" is required by Section 127285 and Section 1216 of the Health and Safety Code. Failure to complete and file this report by February 15, may result in suspension of the facility's license.

Please refer to the instructions as you complete the form. If you have any questions or need assistance in completing the form, please contact the Office at (916) 322-7422 or (916) 323-7685.

I declare the following under penalty of perjury: that I, the current administrator of this health facility, duly authorized by the governing body to act in an executive capacity; that I am familiar with the record keeping system of this facility and the records and logs are true and correct to the best of my knowledge and belief; that I have read this report and am thoroughly familiar with its contents; and that its contents represent an accurate and complete summarization from medical records and logs of the information requested.

Administrator's Name (Please Print)

Administrator's Signature

Date

3. () _____
Area Code Clinic Phone Number

Name of person completing form and /or contact person for any follow-up questions (Please Print)

Print Title and Department of Person Responsible for the Report

() _____
Area Code Phone Ext.

() _____
Area Code FAX Number

	Col. 1	THROUGH	Col. 2
1. FROM	<div style="border: 1px solid black; width: 100%; height: 30px; position: relative;"> <div style="position: absolute; left: 50%; top: -5px; transform: translateX(-50%);"> </div> </div> <div style="display: flex; justify-content: space-around; width: 100%;"> Month Day </div>		<div style="border: 1px solid black; width: 100%; height: 30px; position: relative;"> <div style="position: absolute; left: 50%; top: -5px; transform: translateX(-50%);"> </div> </div> <div style="display: flex; justify-content: space-around; width: 100%;"> Month Day </div>

Please report the total number of individual, unduplicated patients served and the total number of encounters for these patients. Please refer to the INSTRUCTIONS for further detail.

	UNDUPLICATED PATIENTS (1)	ENCOUNTERS (2)
TOTAL, all locations under this license (Main, Mobile, Satellite, etc.)		

Table A

	Line	Number
If you provided abortion services directly at your clinic, provide the total number of abortions performed	25	
Number of surgical operating rooms on December 31	26	
Total of surgical operations performed during the calendar year	27	

Table B* Enter the number of ENCOUNTERS for the year for the following services:

BREAKDOWN OF ENCOUNTERS BY SERVICE TYPE FOR PSYCHOLOGY CLINICS:	Line	Number
General Medical	28	
Substance Abuse (alcohol and drug)	29	
Mental Health Counseling	30	
All Other	31	

*The sum of Lines 28 through 31 must equal Line 19, Col. 2 (Total Encounters)

MAJOR CAPITAL EXPENDITURES

The collection of these data in Tables C and D are mandated by Section 127285(c) of the Health and Safety Code, in order to track the effects of CON deregulation since 1984.

List each acquisition of diagnostic or therapeutic equipment costing **\$500,000** or more in Table C below.

Table C

DIAGNOSTIC/THERAPEUTIC EQUIPMENT ACQUIRED COSTING \$500,000 OR MORE			Date of Acquisition (3)	MEANS OF ACQUISITION 1 = Purchase 2 = Lease 3 = Donation 4 = Other (4)
L i n e	Market Value (1)	OSHPD PROJECT NUMBER (2)		
1				
2				
3				
4				

List the building project(s) your facility commenced during the calendar year in Table D below. List only those which require an aggregate capital expenditure over **\$1,000,000**.

Table D

PROJECTS OVER \$1,000,000 COMMENCED DURING THE CALENDAR YEAR		
L i n e	Projected Total Capital Expenditure (1)	OSHPD PROJECT NUMBER (2)
21		
22		

FINANCIAL DATA FOR CALENDAR YEAR

Table E Please round to the nearest dollar, do not enter cents!

Line		
23	Total Charges for all patients and 3rd party payers	\$
24	Other Income (Revenue) from other sources (enter 0 if none)	\$
25	Total Operating Cost	\$
26	Net Operating Income (Revenue)	\$